HEALTHY TEETH
PEDIATRIC DENTISTRY

Today's Date _____

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

How did you hear about us? ☐Internet ☐Insurance ☐Magazine ☐Friend ☐Other

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
School _____ Grade _____
Child's Home Address _____
City _____ State _____

Mother

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Name _____ ☐Stepmother ☐Guardian
Home Phone _____ Work Phone _____
Cell Phone _____
Employer _____ Occupation _____
DL# _____

Father

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Name _____ ☐Stepfather ☐Guardian
Home Phone _____ Work Phone _____
Cell Phone _____
Employer _____ Occupation _____
DL# _____

Responsible Party

Name _____ Relationship _____
Address _____
Home Phone _____ Work Phone _____
Cell Phone _____
SS#/SIN _____ DL# _____
Email _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Occupation _____
Ins. Company _____ Group # _____ Emp # _____
Ins. Company Address _____
Deductible _____
Amount already used _____ Max. annual benefit _____

Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous visits? _____

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____

Is your child taking any medications? _____

Is your child allergic to any medications? Please specify _____

Has your child ever had any of the following:

Asthma	☐YES	☐NO	Rheumatic Fever	☐YES	☐NO
Cancer	☐YES	☐NO	Congenital Heart Defect	☐YES	☐NO
Hepatitis	☐YES	☐NO	Handicaps/Disabilities	☐YES	☐NO
HIV/AIDS	☐YES	☐NO	Convulsions/Epilepsy	☐YES	☐NO
Hemophilia	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Diabetes	☐YES	☐NO	Abnormal Bleeding	☐YES	☐NO
Allergies	☐YES	☐NO	Heart Murmur	☐YES	☐NO
Artificial Valves	☐YES	☐NO	Sickle Cell Disease/Trait	☐YES	☐NO
High Blood Pressure	☐YES	☐NO	Nervous Problem	☐YES	☐NO
Low Blood Pressure	☐YES	☐NO	Autism	☐YES	☐NO
Thyroid Disease	☐YES	☐NO	Renal Disease/Kidney Failure	☐YES	☐NO
			ADHD	☐YES	☐NO

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____ Phone Number _____

Is your child's water fluoridated? ☐YES ☐NO

Does your child take fluoride supplements? ☐YES ☐NO

Does your child:

Suck thumb/finger	☐YES	☐NO	Chew hard objects (pencils, etc)	☐YES	☐NO
Suck/Bite lips	☐YES	☐NO	Grind teeth	☐YES	☐NO
Bite/Chew nails	☐YES	☐NO	Clench jaws	☐YES	☐NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Parent or Guardian if minor Date

Health History Update

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____